

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Delbarton</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Queen Anne</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Queenstown</i>		d. STREET ADDRESS <i>17X-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ros Vista Nursing Home</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>BESSIE</i>		First <i>BESSIE</i>	Middle <i>PRICE</i>	Lost <i>BENNETT</i>	4. DATE OF DEATH <i>Nov. 23 1960</i>	Month <i>Nov.</i>	Day <i>23</i>	Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 27-1872</i>	9. AGE (In years lost birthday) <i>88</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>In Queenstown Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>William H. Price</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Bryan</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mr. Lamm Price Carter Queenstown Maryland</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422-1</i>		DUE TO <i>Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Arteriosclerotic Cardiovascular Syst.</i>		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Box 487, St. Michaels, Md</i>		(County) <i>Queen Anne</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>27 Aug 1960</i> to <i>23 Nov 1960</i> , that I last saw the deceased alive on <i>31 Oct 1960</i> , and that death occurred at <i>6:00 AM</i> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>R. Handforth</i>		ADDRESS (Street, city or town, state) <i>Box 487, St. Michaels, Md 21124-60</i>							DATE SIGNED <i>11-24-60</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 26-1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Chesterfield Cemetery</i>		22d. LOCATION (City, town, or county) <i>Centreville Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas Bartholomew Bess</i>		ADDRESS <i>Centreville Md</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 30 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Finch</i>			

DEPARTMENT OF HOMELAND SECURITY

CERTIFICATE OF DEATH

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1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be reached by the hospital or attending physician.  
2  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

13039 See Birth Cert. et 14365

1. PLACE OF DEATH  
a. COUNTY **TALBOT** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **EASTON** c. LENGTH OF STAY IN 1b **16 da**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **EASTON Memorial Hosp.**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE **Maryland** b. COUNTY **Queen Anne's**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Chester** 17x-2

d. STREET ADDRESS **---**

e. IS RESIDENCE ON A FARM?  
YES  NO

3. NAME OF DECEASED (Type or print) **DARRY /** First **Sidney** Middle **Last** **Bordley** 4. DATE OF DEATH **11 - 22 19 60**

S. SEX **male** 6. COLOR OR RACE **black** 7. MARRIED  NEVER MARRIED  8. DATE OF BIRTH **11/6/60** 9. AGE (In years 1st birthday) **18 days** 10. IF UNDER 1 YEAR **16** IF UNDER 24 HRS.  
WIDOWED  DIVORCED  Months **16** Days **0** Hours **0** Min. **0**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Maryland**

12. CITIZEN OF WHAT COUNTRY? **Armeta Bordley**

13. FATHER'S NAME **Montro Wright** 14. MOTHER'S MAIDEN NAME **Armeta Bordley**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **776X** 16. SOCIAL SECURITY NO. **Armeta Bordley Chester Maryland** 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] **Prematurity** 19. INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **776X** DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) **---**  
DUE TO (c) **---**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?  
IF EITHER, NOTIFY MEDICAL EXAMINER **YES  NO**

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year (County) (State)  
Hour o. m. **19** 20. INJURY OCCURRED While **---** Nat while **---** 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) **---** (County) **---** (State) **---**

20. INJURY OCCURRED While **---** Nat while **---** 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) **---** (County) **---** (State) **---**

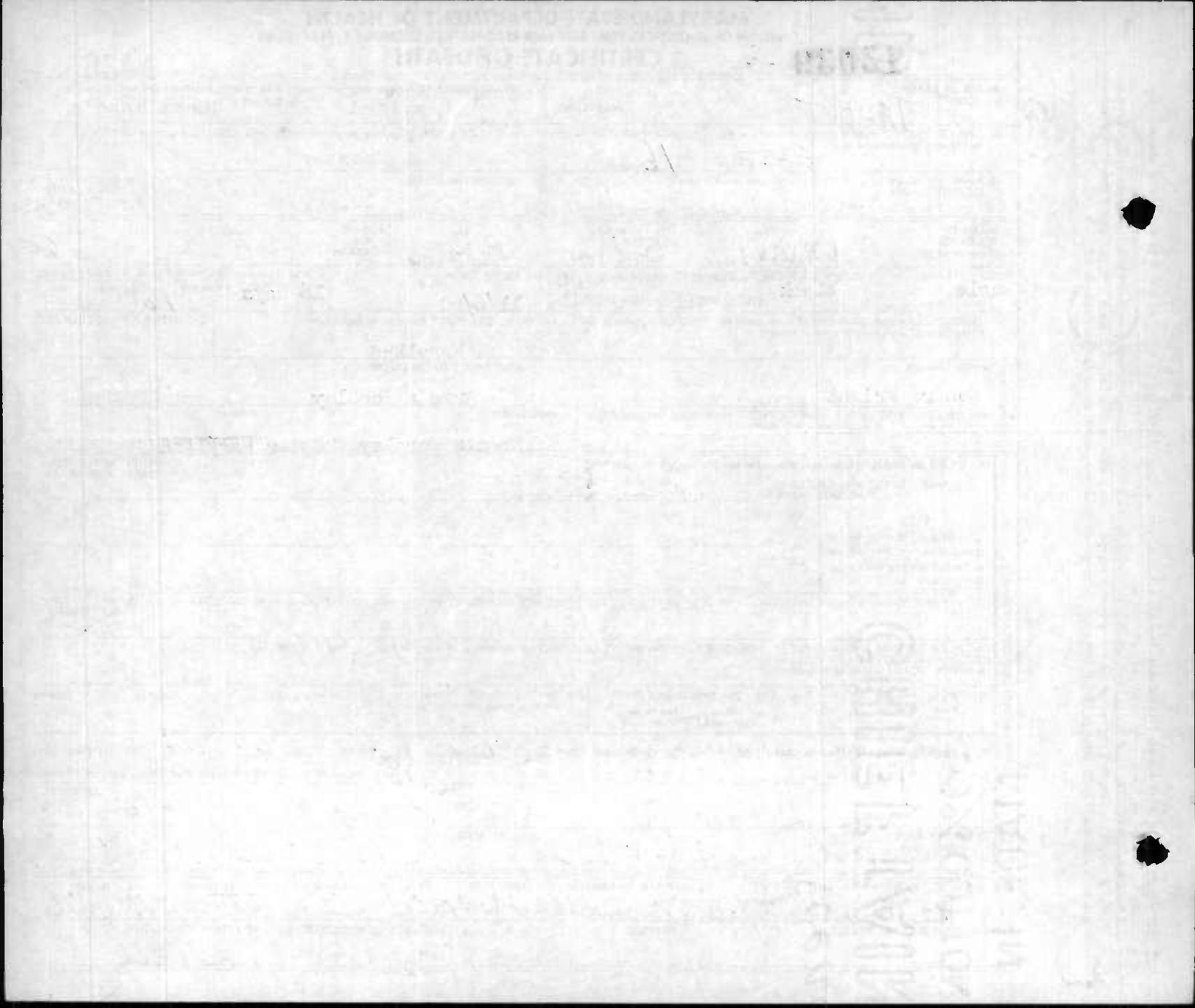
21. I certify that (I) (this hospital) attended the deceased from **11/6/60** to **17/22 19 60** that (I) (we) lost the deceased alive on **11/20 19 60**, and that death occurred at **12 PM**, from the causes and on the date stated above.

22a. SIGNATURE **Irvin G. Hoyt MD** 22b. DATE SIGNED **11/6/60**

22c. PHYSICIAN'S NAME (Type) **Irvin G. Hoyt MD** M.D. ATTENDING PHYS.  MED. DIRECTOR  STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify) **Incineration** 23b. DATE THEREOF **11/28/60** 23c. NAME OF CEMETERY OR CREMATORIAL **Memorial Hospital Chester, Maryland** 23d. LOCATION (City, town, or county) (State) **---**

24. FUNERAL DIRECTOR'S SIGNATURE **Irvin G. Hoyt MD** ADDRESS 25a. REC'D BY REGISTRAR DATE **DEC 12 60** 25b. REGISTRAR'S SIGNATURE **Arthur S. Evans**



1  
FOR STATE  
HEALTH DEPT.

M

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM 1. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13067 15

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
a. COUNTY	Talbot	a. STATE	Maryland
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	W. Trappe	b. COUNTY	Talbot
c. LENGTH OF STAY IN lb	47 yrs.	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	X TRAPPE RURAL
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH	Month	Day	Year
PIETRO			BORGAS JR.	Nov	30	1960

5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MAR 27, 1883	17 yrs.	Months	Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MACHINIST		ITALY (Milan)	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
PAUL BORGA.	CECILA MARTHA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
			Pietro Borga Cambridge Md.

18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	Coronary occlusion
DUE TO (b)	Normal
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
---	--

20c. TIME OF INJURY Hour C 3 p.m.	Month, Day, Year 19	20d. WHERE OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
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ACTUAL SIGNATURE Lori Breetz	CHIEF MEDICAL EXAMINER <input type="checkbox"/>
---------------------------------	---

EXAMINER'S NAME (Type) WEITZ	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 2, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Landing Neck Cem.	22d. LOCATION (City, town, or country) Easton (Rural) Md. (State)
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23. FUNERAL DIRECTOR Maurice E. Newmann & Son	ADDRESS Easton Md.	24a. REC'D BY REGISTRAR Date DEC 6 '60	24b. REGISTRAR'S SIGNATURE Cathleen S. Trahan
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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13016

13040

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eastern</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Memorial Hosp.</i>		e. STREET ADDRESS <i>Chew Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Minnie</i>		First <i>May</i>	Middle <i>Bottiger</i>
4. DATE OF DEATH <i>Nov. 17 1960</i>		Month <i>Nov.</i>	Day <i>17</i>
5. S. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>DEC 18 1879</i>		9. AGE (In years last birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR Months <i>80</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>ST. MICHAELS</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>HARRISON SPURRY</i>	
14. MOTHER'S MAIDEN NAME <i>VIRGINIA PARROT</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>William Bottiger, St. Michaels.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1010.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Circumnecrosis Origin unk. 1010.2</i>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>St. Michaels, Maryland</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>14 Nov 1960</i> to <i>17 Nov 1960</i> , that (I) (we) last saw the deceased alive on <i>17 Nov 1960</i> and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>11-18-60</i>	
22a. SIGNATURE <i>R. Lane Wroth</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>R. Lane Wroth</i>		22d. ADDRESS <i>St. Michaels, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-21-60</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Oliver Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Michaels, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>S. Hambleton Harrison, St. Michaels, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 23 '60</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13064

## CERTIFICATE OF DEATH

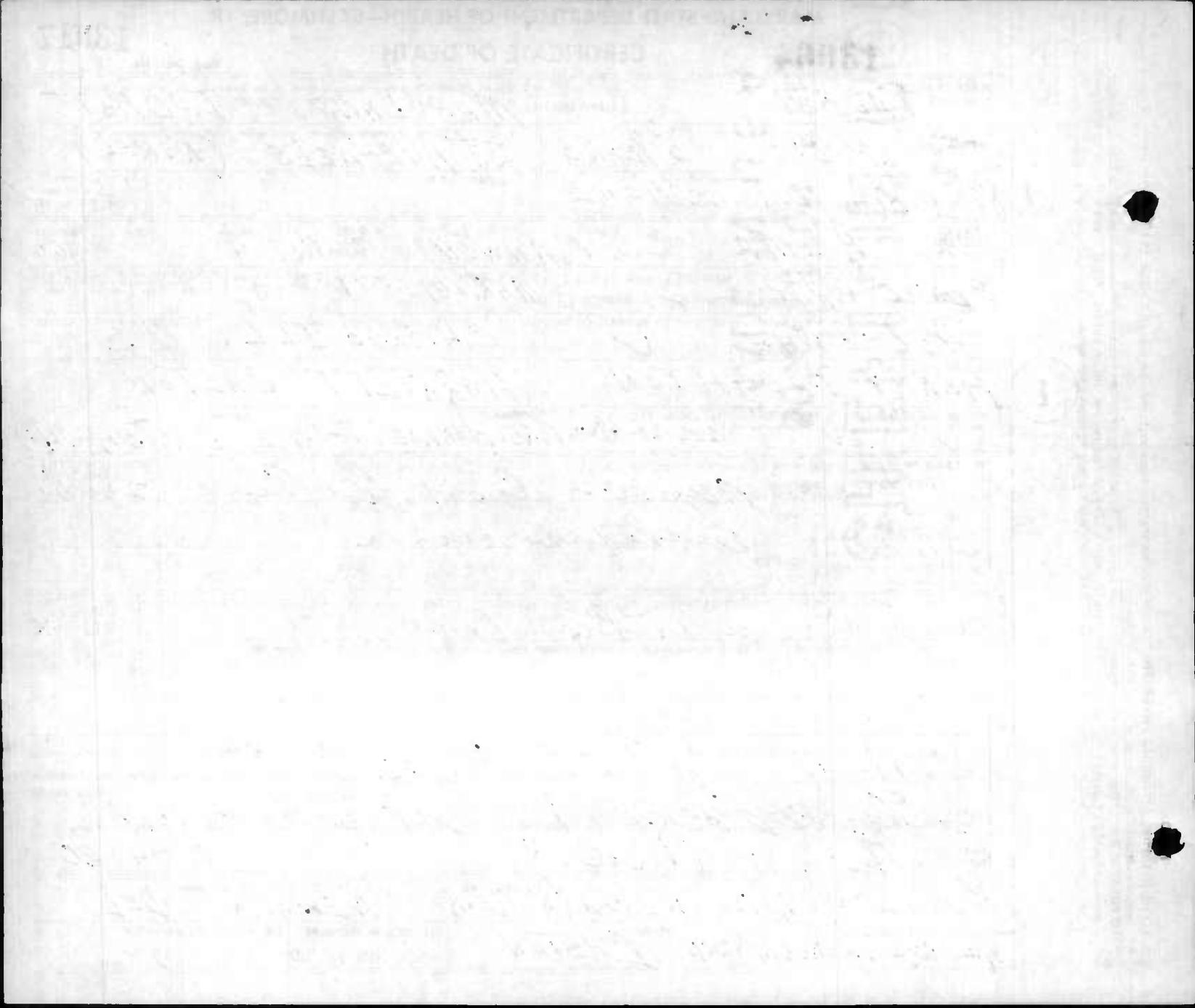
Reg. Dist. No.

13017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MICHAELS</b>		c. LENGTH OF STAY IN 1b <b>5 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIO VISTA NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALMA</b>		First <b>C.</b>	Middle <b>CANNON</b>
Last <b>ALMA</b>		4. DATE OF DEATH <b>NOV. 4</b>	Month <b>NOV.</b>
5. SEX <b>FE female</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>MAR. 14, 1881</b>		9. AGE (In years last birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>✓</b>	11. BIRTHPLACE (State or foreign country) <b>CHICAGO ILL.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>HARRY BOUGHTON</b>	
14. MOTHER'S MAIDEN NAME <b>HARRIETT CALTON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>✓</b>	
16. SOCIAL SECURITY NO. <b>222-20-4760</b>		17. INFORMANT <b>MRS. HARRIETT PRICE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b>		Address <b>EASTON-MD.</b>	
DUE TO <b>332</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>ice</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
(b) <b>ice</b>			
DUE TO <b>ice</b>			
(c) <b>ice</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>cerebral vascular thrombosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>✓</b> (County) <b>✓</b> (State) <b>✓</b>	
21. I certify that I attended the deceased from <b>2-24</b> , 19 <b>58</b> , to <b>11-4</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>11-4</b> , 19 <b>60</b> , and that death occurred at <b>4:50 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rey M Peeler</b>		ADDRESS (Street, city or town, state) <b>St. Michaels 412</b>	
PHYSICIAN'S NAME (Type) <b>Rey M Peeler</b>		DATE SIGNED <b>11-4-60</b>	
22a. BURIAL, CREMATION, REASON (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 7, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>NEWARK CEM.</b>		22d. LOCATION (City, town, or county) <b>NEWARK DEL.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall Newman &amp; Son</b>		ADDRESS <b>EASTON</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Circling S. Kline</b>	

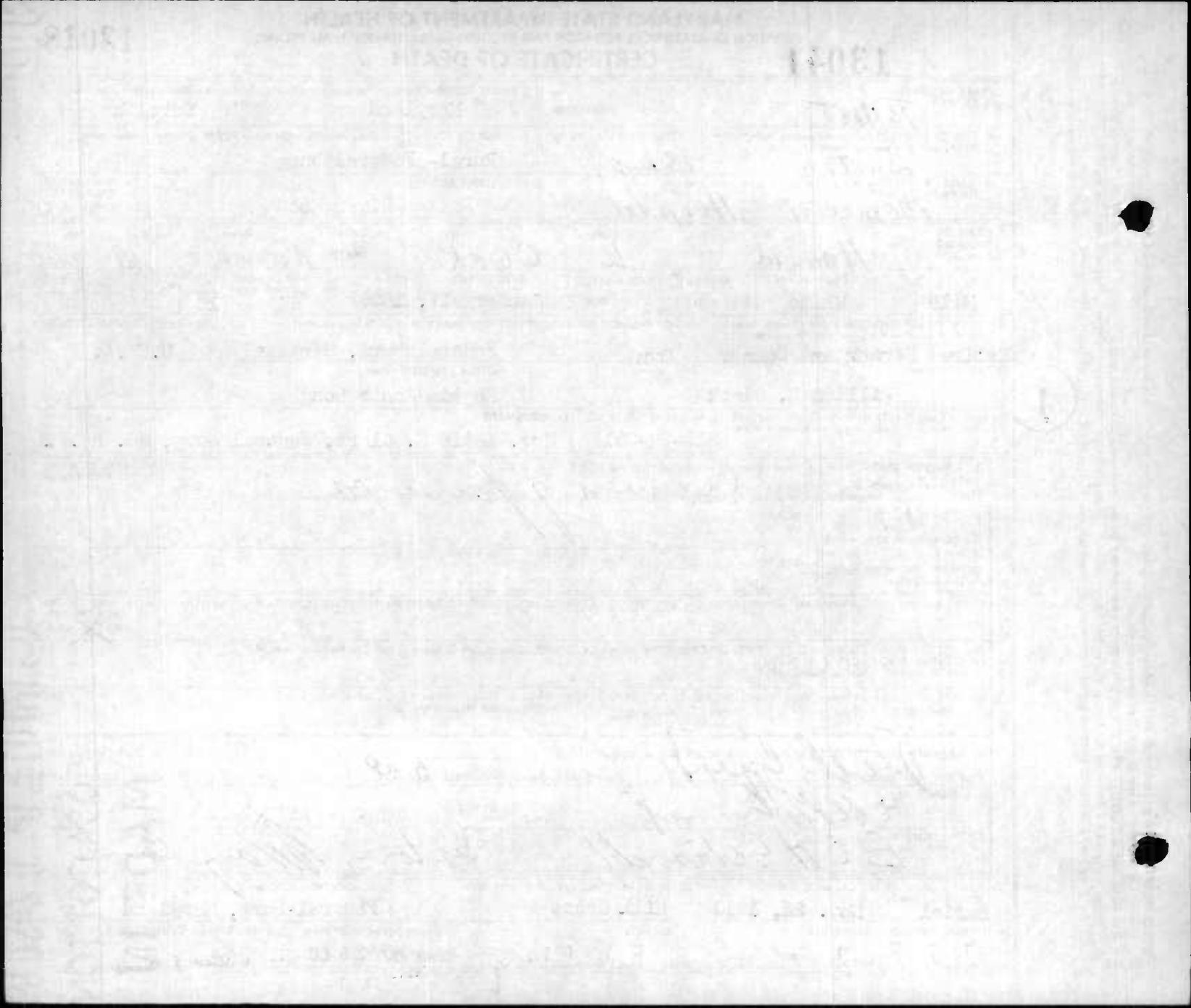


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13041 CERTIFICATE OF DEATH 13018

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>13 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural- Federalsburg</i>		d. STREET ADDRESS <i>River Road</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Harold</i>		First <i>H</i> .	Middle <i>L.</i>	Last <i>Clark</i> .	4. DATE OF DEATH <i>November 19 1960</i>	Month <i>November</i>	Day <i>19</i>	Year <i>1960</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>January 17, 1896</i>	9. AGE (In years last birthday) <i>64 yrs.</i>	IF UNDER 1 YEAR <i>10 months</i>		IF UNDER 24 HRS. <i>2 days</i>
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			10. KIND OF BUSINESS OR INDUSTRY <i>Retired Farmer and Canner</i>	11. BIRTHPLACE (State or foreign country) <i>Federalsburg, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William H. Clark</i>				14. MOTHER'S MAIDEN NAME <i>Sophia Annie Long</i>		Address <i>Mrs. Katie S. Clark, Federalsburg, Md. R.F.D.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>213-20-0813</i>		17. INFORMANT <i>Carey</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		
						INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Easton</i>		(County) <i>Maryland</i> (State) <i>Maryland</i>
21. I certify that (I) (This hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.						22b. DATE SIGNED		
22a. SIGNATURE <i>E.C. H. Schmidt</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22d. ADDRESS <i>Easton, Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 22, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Hill Crest</i>		23d. LOCATION (City, town, or county) <i>Federalsburg, Maryland</i> (State) <i>Maryland</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Frampton and Son</i>		ADDRESS <i>Federalsburg</i>		25a. REC'D BY REGISTRAR <i>NOV 28 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>		



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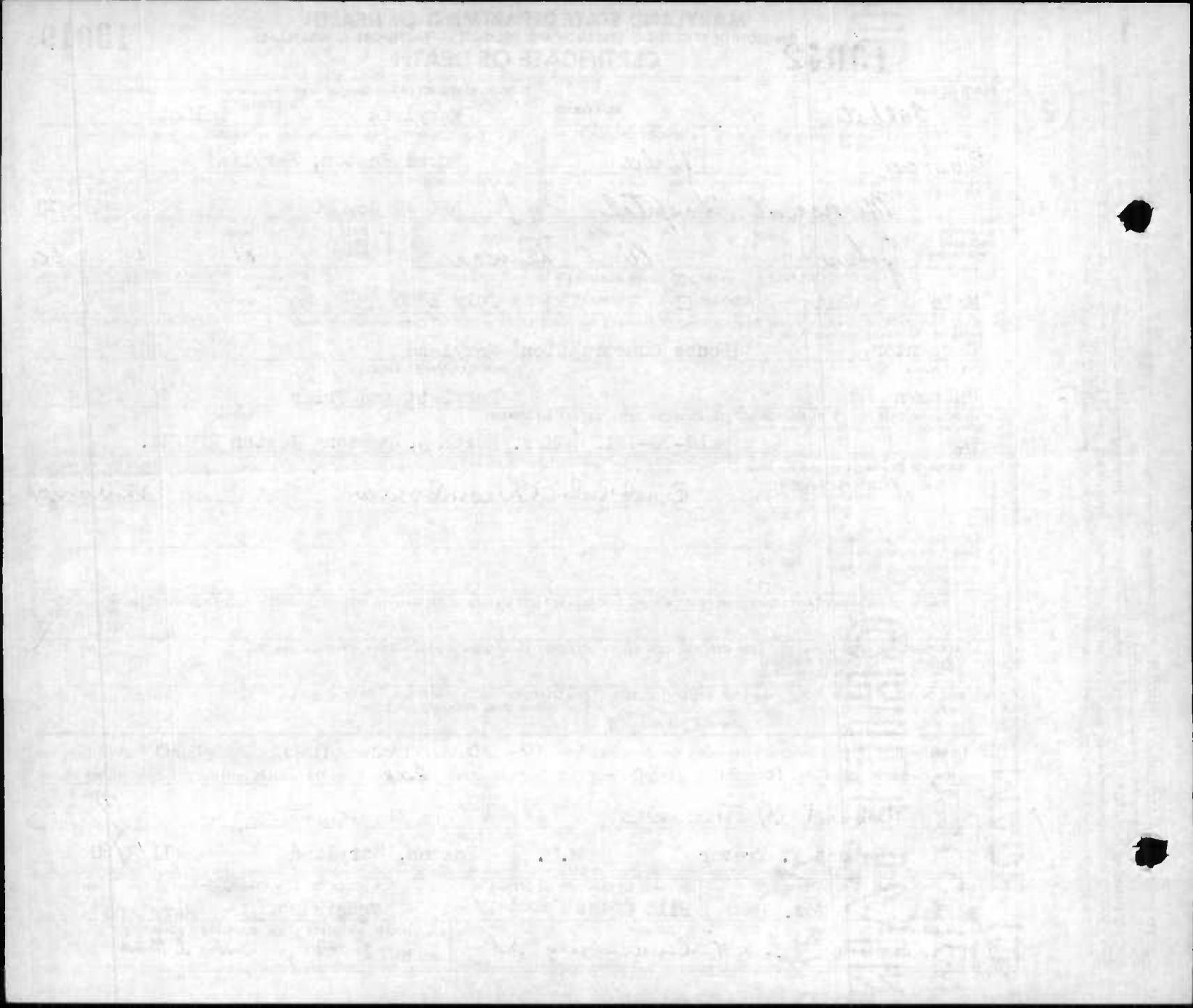
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13042 13019

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>11 da</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John</i>	First <i>W.</i>	Middle <i>Dawson</i>	4. DATE OF DEATH Month <i>11</i> Day <i>1</i> Year <i>1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>28 July 1880</i>
9. AGE (In years last birthday) <i>80</i> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>	11. KIND OF BUSINESS OR INDUSTRY <i>House Construction</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Harriett Ann Trice</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>218-09-4213</i>	17. INFORMANT <i>Mrs. Edith B. Dawson</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Cerebral thrombosis INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10-30</i> 19 <i>60</i> , to <i>11-1</i> 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>10-31</i> 19 <i>60</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Trever</i>	M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11/3/60</i>
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>	M.D.	22d. ADDRESS <i>Easton, Maryland</i>	<i>11/3/60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>3 Nov. 1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Hill Crest Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Federalsburg Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Trumpton and Son, Federalsburg, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>NOV 7 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13043

## CERTIFICATE OF DEATH

Reg. Dist. No.

13020

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1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	c. LENGTH OF STAY IN 1b 2 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		d. STREET ADDRESS 514 Goldsborough St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First HERBERT	Middle NATHANIEL	Last FLOYD			
4. DATE OF DEATH November 19, 1960	Month Nov	Day 19	Year 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1912			
9. AGE (In years last birthday) 48 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	11. KIND OF BUSINESS OR INDUSTRY Comm. printing	12. BIRTHPLACE (State or foreign country) Georgia			
13. FATHER'S NAME John F. Floyd	14. MOTHER'S MAIDEN NAME Anna Herst					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 577-03-3508	17. INFORMANT Mrs. Freda C. Floyd, Easton, Maryland	18. 514 Goldsborough St., Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO <i>Sudden</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>atherosclerotic coronary dis</i> ? (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. MEDICAL CERTIFICATION ACTUAL SIGNATURE P. Evans Cox, M. D.	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1959</i> to <i>Nov 1960</i> that I last saw the deceased alive on <i>July 10, 1959</i> , and that death occurred at <i>5-2</i> M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>Easton, Md</i>		DATE SIGNED <i>1/22/60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov 22, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Neavitt Cemetery	22d. LOCATION (City, town, or county) (State) Neavitt, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Hamerton Harrison, St. Michaels</i>	ADDRESS <i>St. Michaels</i>	24a. REC'D BY REGISTRAR DATE NOV 23 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

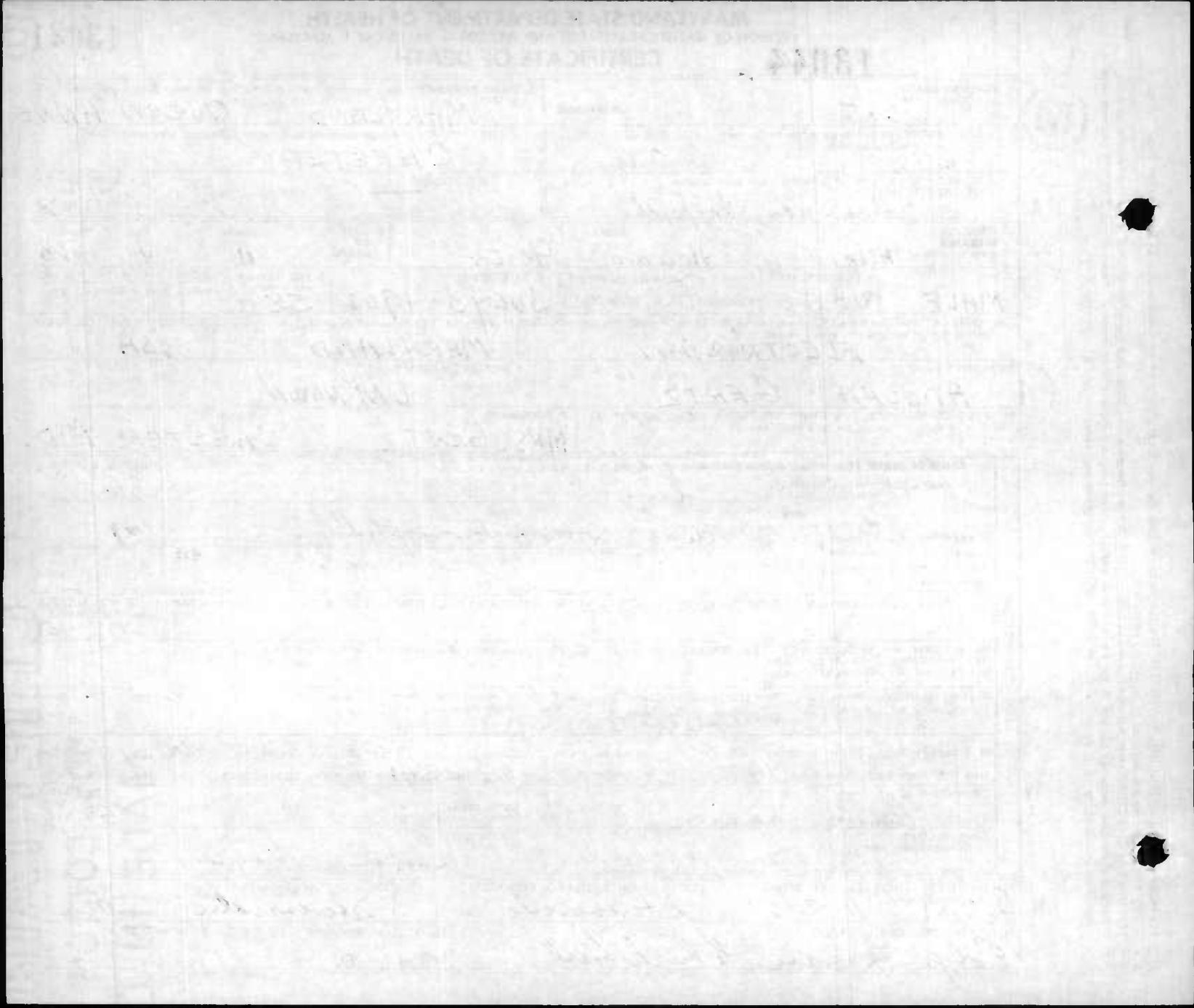


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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

13021

1. PLACE OF DEATH a. COUNTY <i>Bel Air</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		b. COUNTY <i>QUEEN ANNE</i>	
c. LENGTH OF STAY IN 1b <i>2 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHESTER</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>17 x-2</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Albert</i>	Middle <i>Howard</i>	Last <i>Gertz</i>
4. DATE OF DEATH	Month <i>11</i>	Day <i>4</i>	Year <i>1960</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 3-1902</i>
9. AGE (In years last birthday) <i>58 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ELECTRICIAN</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>ADOLPIT GERTZ</i>	14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	Address <i>CHESTER MD.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>592</i>			
16. SOCIAL SECURITY NO. <i>123-45-6789</i>			
17. INFORMANT <i>MRS. GERTZ</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteria</i>			
DUE TO <i>Chronic glomerulo - nephritis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>3 mo</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteria</i> (c) <i>Chronic glomerulo - nephritis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>May</i>		(County) <i>1960</i> (State) <i>4 Nov 1960</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>May 1960</i> to <i>4 Nov 1960</i> , that (I) (we) last saw the deceased alive on <i>4 Nov 1960</i> , and that death occurred at <i>4:45 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Harrison</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>6 Nov 60</i>
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>		22d. ADDRESS <i>Carver Mayland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/7/60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Stevensville</i>
23d. LOCATION (City, town, or county) <i>Stevensville</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i>		25a. REC'D BY REGISTRAR <i>Edgar L. Lane</i>	25b. REGISTRAR'S SIGNATURE <i>Edgar L. Lane</i>
ADDRESS <i>Church Hill</i>		DATE <i>Nov 9 '60</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

M

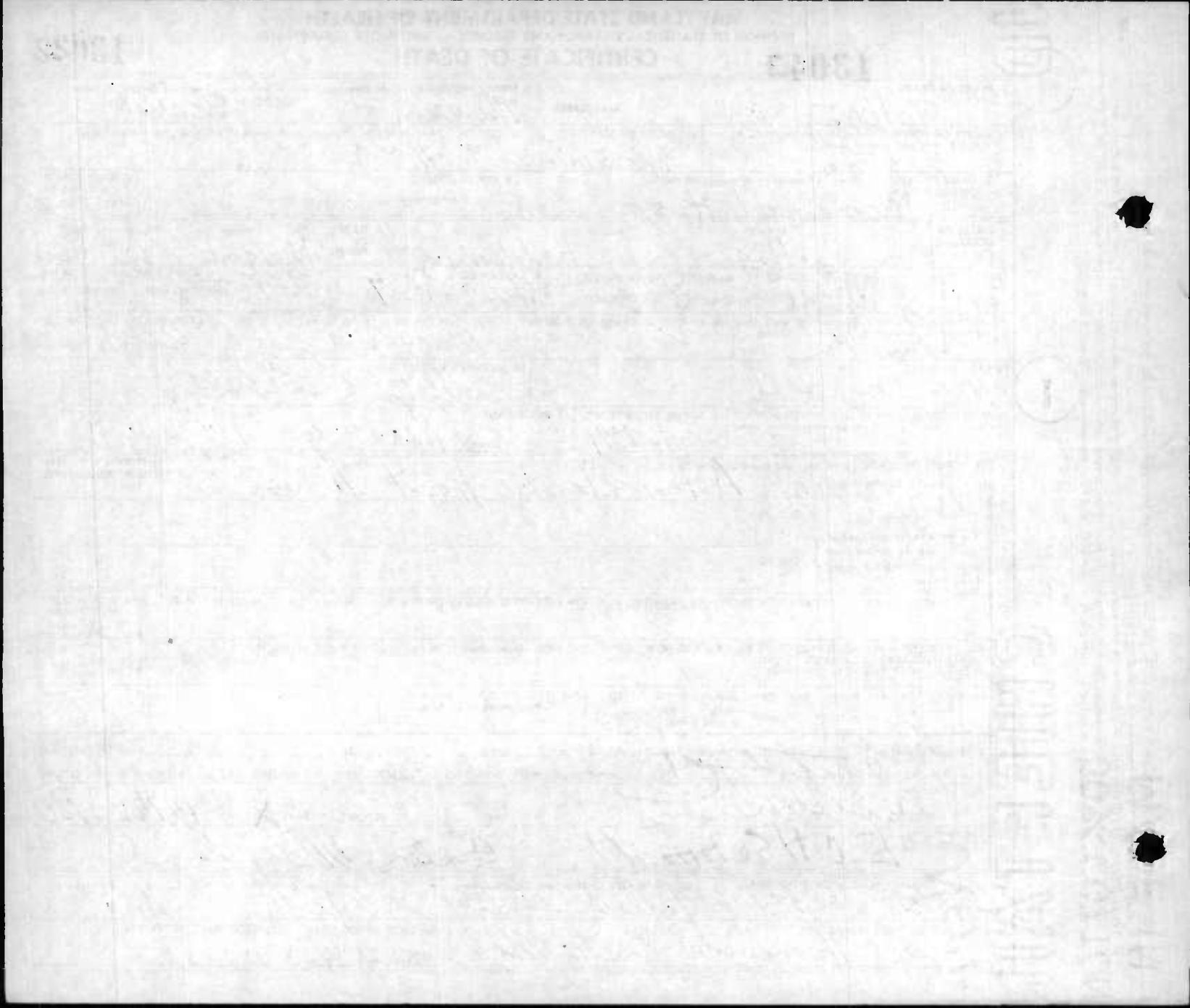
13045

13022

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>1 hr. 5 min.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxford</i>		d. STREET ADDRESS <i>Memorial Hosp.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Lillian</i>		First	Middle	Lost	4. DATE OF DEATH <i>November 15 1960</i>	Month	Day	Year
SEX <i>Female</i>		6. COLOR OF FACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 7, 1887</i>	9. AGE (In years lost birthday) <i>73 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>✓</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>William Hill</i>		14. MOTHER'S MAIDEN NAME <i>Elma J. Gibson</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>420.0</i>		16. SOCIAL SECURITY NO. <i>212-16-7399</i>		17. INFORMANT <i>Charles Haddaway</i>		Address <i>Oxford Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> lying cause last. (b) DUE TO <i>420.0</i>								
(c) DUE TO <i></i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <i>5:45 AM</i> , from the causes and on the date stated above.								
22a. SIGNATURE <i>E. C. H. Schmidt</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <i>15 Nov 1960</i>		
22c. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>		22d. ADDRESS <i>Easton, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 17, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Oxford Cemetery</i>		23d. LOCATION (City, town, or county) <i>Oxford</i>		(State) <i>Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice C. Newington</i>		ADDRESS <i>Easton Md.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 21 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13023

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

**13046**

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 hrs.</i>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First <i>Benjamin</i>	Middle <i></i>	Last <i>Hayden</i>							
4. DATE OF DEATH	Month <i>November</i>	Month <i>9</i>	Day Year <i>1960</i>							
5. SEX <i>Male</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 7 - 1886</i>							
9. AGE (In years last birthday) <i>74 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAINTER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>							
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>BENJAMIN HAYDEN</i>									
14. MOTHER'S MAIDEN NAME <i>CATHERINE CUNKLE</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)									
16. SOCIAL SECURITY NO. <i>218-07-2348A</i>	17. INFORMANT	Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>421</i> <b>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</b> <i>Leante left ventricular failure</i> <b>DUE TO</b> <b>(b)</b> <i>Calific aortic stenosis</i> <b>DUE TO</b> <b>(c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Apr. 10 1958</i> to <i>9 Nov 1960</i> , that (I) (we) last saw the deceased alive on <i>9 Nov 1960</i> , and that death occurred at <i>7:25 P.M.</i> from the causes and on the date stated above.				22a. SIGNATURE <i>Houston Harrison</i>	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>9 Nov 60</i>				
22c. PHYSICIAN'S NAME (Type) <i>Houston Harrison</i>	22d. ADDRESS <i>Centreville</i>			23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE THEREOF <i>10/12/60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Centreville</i>	23d. LOCATION (City, town, or county) <i>Centreville</i>	(State) <i>MD.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane</i>				ADDRESS <i>Church Hill</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 14 1960</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thrall</i>				



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13047

## **CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>8 days.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McDaniel</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>NO</b>		
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First	Middle	Last	4. DATE OF DEATH <b>11</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1911</b>	9. AGE (In years last birthday) <b>49</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Harry F. Kellermen</b>			14. MOTHER'S MAIDEN NAME <b>Maria Louisa Nickerson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>ukn</b>		17. INFORMANT <b>William F. Howeth, Jr. McDaniel, Maryland</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> 170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Carcinoma of Breast</b> <b>5 years.</b> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> 19. WAS AUTOPSY (If either, notify medical examiner) PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Van</b>		20f. (City or town) <b>11/15</b>		(County) <b>1960</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1 1954</b> to <b>11/15 1960</b> , that (I) (we) last saw the deceased alive on <b>11/15 1960</b> , and that death occurred <b>3:45 PM</b> , from the causes and on the date stated above.								
22a. SIGNATURE <b>Krech Jr</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/16/60</b>				
22c. PHYSICIAN'S NAME (Type) <b>Shepard Krech Jr</b>		22d. ADDRESS <b>Easton, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/18/60</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Spring Hill Cemetery</b>		23d. LOCATION (City, town, or county) <b>Easton, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Crampston Carroll</b>		ADDRESS <b>Castor, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>		

5  
PAGE FORTY-FIVE

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be reprinted by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13025

**13048**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>30 min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHLEHEM</b>	
d. STREET ADDRESS <b>OSX-2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle <b>Frances</b>	Last <b>Hanley</b>
4. DATE OF DEATH	Month <b>November</b>	Day <b>12</b>	Year <b>1960</b>
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 4 1888</b>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>72 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Chetham</b>		14. MOTHER'S MAIDEN NAME <b>Frances Fitzgerald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>✓</b>	
17. INFORMANT <b>Mrs. Euseah Hanley</b>		Address <b>Boston Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b>			
DUE TO <b>420.0</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Arteriosclerotic heart disease</b>			
DUE TO (c) <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-12 1960</b> to <b>11-12 1960</b> , that (I) (we) last saw the deceased alive on <b>11-12 1960</b> and that death occurred at <b>445 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Trever</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 16, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Philadelphia Memorial Park</b>		23d. LOCATION (City, town, or county) <b>Frazier - Chestico - Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		ADDRESS <b>Easton, Md</b>	
25a. REC'D BY REGISTRAR DATE <b>NOV 17 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Trahan</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13049

## CERTIFICATE OF DEATH

13026

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>33 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>	
d. STREET ADDRESS <b>415 AUGUST ST. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES-</b>		First <b>E</b>	Middle <b>KEMP.</b>
4. DATE OF DEATH <b>Nov. 6, 1960</b>		Last <b>K</b>	Month Year <b>Nov. 6, 1960</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY. 16, 1863</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>THOMAS-J-KEMP.</b>		14. MOTHER'S MAIDEN NAME <b>CLARICE WYATT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. <b>218-20-2703</b>	INFORMANT <b>Mrs. Daugherty Kunkle</b> Address <b>Easton Md</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cerebral Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Arteriosclerosis, generalized</b> (c) <b>years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7/6</b> , 19 <b>59</b> , to <b>11/6</b> , 19 <b>60</b> that I last saw the deceased alive on <b>11/6</b> , 19 <b>60</b> , and that death occurred at <b>2 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. J. Eglader</b>		ADDRESS (Street, city or town, state) <b>12 N. HANSON ST 11/260</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 9, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Spring Hill Cem</b>
22d. LOCATION (City, town, or county) <b>Easton</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newberry &amp; Son</b>		24a. ADDRESS <b>Easton Md</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>
VS A15 (4) 1SM 9/58		DATE <b>NOV 14 '60</b>	

PRINTED IN U.S.A. 1970 1971

1  
FOR STATE  
HEALTH DEPT.

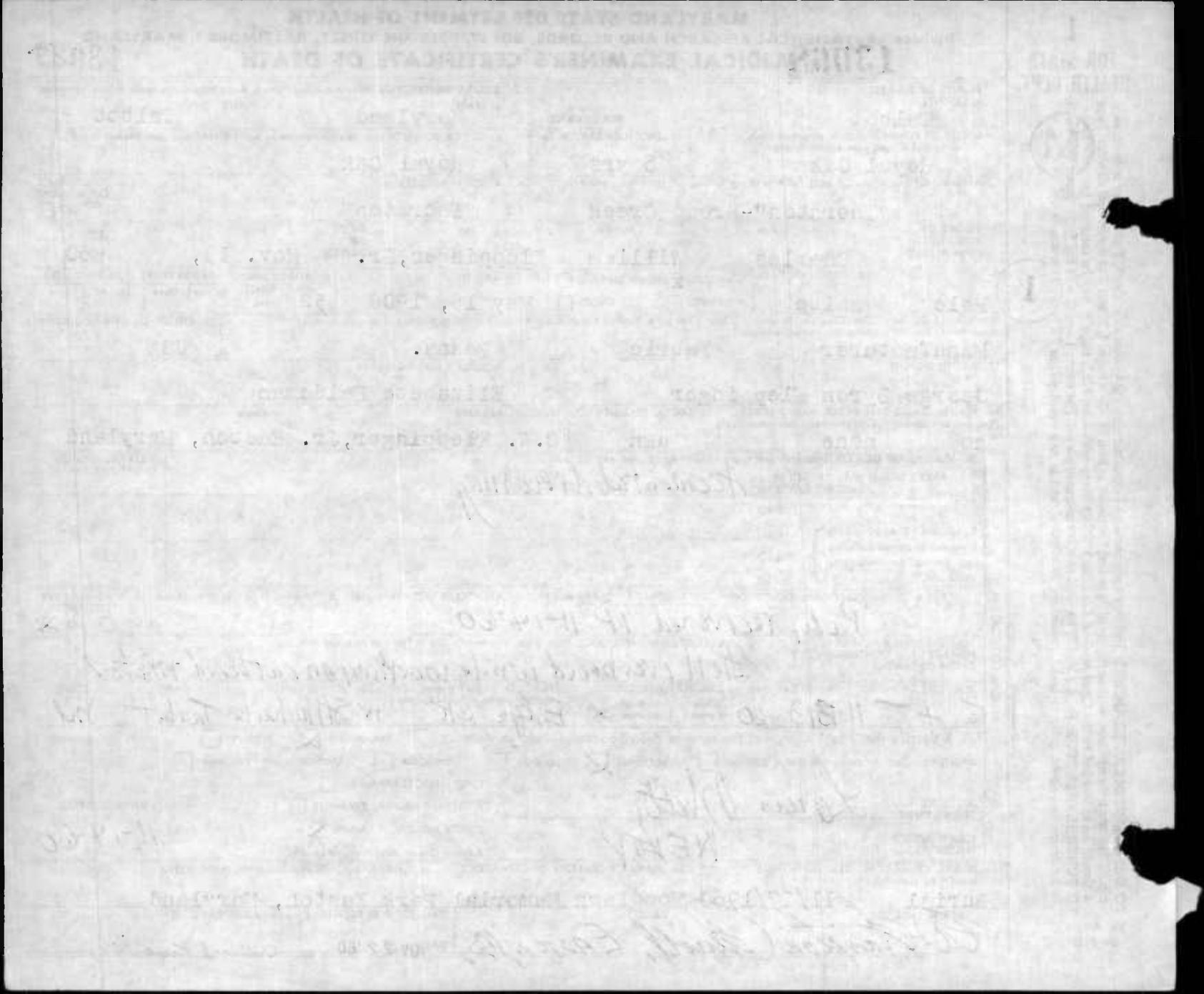
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13027

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak		c. LENGTH OF STAY IN 1b 6 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Royal Oak		d. STREET ADDRESS "Thornton"-Broad Creek		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) "Thornton"-Broad Creek				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Charles William Kleppinger, Sr.		First	Middle	Last	4. DATE OF DEATH Nov. 13, 1960	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1908		9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer		10b. KIND OF BUSINESS OR INDUSTRY Fabric		11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Byron Kleppinger				14. MOTHER'S MAIDEN NAME Elizabeth Haldeman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. u kn		17. INFORMANT C.W. Kleppinger, Jr. Easton, Maryland		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 850 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Accidental drowning				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Body recovered 1P 11-14-60								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall overboard while working on outboard motor		20c. TIME OF INJURY Month, Day, Year 11-13 1960		20d. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Edge of water, St Michaels Talbot Md		20e. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Burial		Luis D. Netty WEKTV		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-14-60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/1960		22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Memorial Park Easton, Maryland		22d. LOCATION (City, town, or country) Easton, Maryland		(State)
23. FUNERAL DIRECTOR R. Hampton Arnall, Easton, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 22 '60		24b. REGISTRAR'S SIGNATURE John S. Thomas		
VS. A15ME 5M 7/59								

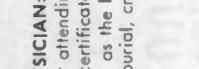
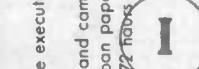


or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

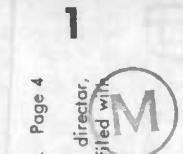


090

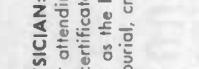
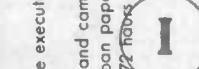


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13029



090



1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>		c. LENGTH OF STAY IN 1b <i>several yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Res. Vista Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Rozelle Connally McClelland</i>		4. DATE OF DEATH Month <i>11</i> Day <i>15</i> Year <i>1960</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/29/1881</i>	
9. WIDOWED <input checked="" type="checkbox"/>		10. DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
10c. BIRTHPLACE (State or foreign country) <i>Tenn</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James F. Connally</i>		14. MOTHER'S MAIDEN NAME <i>Sillian Ebaugh</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>7220</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>James A. McClelland, Easton Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7220</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Congestive Heart Failure</i> <i>Rheumatoid Arthritis</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> 20d. INJURY OCCURRED p. m. <i></i> While <i></i> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i>15 October 1960</i>	
21. I certify that (I) (his hospital) attended the deceased from <i>15 October 1960</i> to <i>15 November 1960</i> , that (I) (we) last saw the deceased alive on <i>5 Nov 60</i> and that death occurred at <i>15 Nov 60</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>11-6-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. Paul Crotty</i>		22d. ADDRESS <i></i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/9/60</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>Old Trinity</i>		23d. LOCATION (City, town or county) (State) <i>Chesapeake Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Thomas</i>		25a. REG'D BY REGISTRAR DATE NOV 16 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

21861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

13050

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>3 hours.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>		d. STREET ADDRESS <i>RFD #2 Box 71</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Lavina</i>		First	Middle	Last	4. DATE OF DEATH <i>Miller</i>	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>August 6, 1907</i>	9. AGE (In years last birthday) <i>53 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>C. Webster Pringle</i>				14. MOTHER'S MAIDEN NAME <i>Harriett Tilley</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-01-1202</i>		17. INFORMANT <i>Mr. Harold Miller</i>		Address <i>RFD #2 Box 71 Denton, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock</i>								
DUE TO <i>420.0</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Acute myocardial infarction</i>								
INTERVAL BETWEEN ONSET AND DEATH <i>&lt;12 hrs.</i>								
(c) <i>Arteriosclerotic heart disease</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19 19								
21. I certify that (I) (this hospital) attended the deceased from <i>11-12 1960</i> to <i>11-12 1960</i> that (I) (we) last saw the deceased alive on <i>11-12 1960</i> , and that death occurred <i>5:40 AM</i> , from the causes and on the date stated above.								
22a. SIGNATURE <i>Robert W. Trever</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>		22d. ADDRESS <i>Easton, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 15, 1960</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Denton Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Denton Maryland</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Frampton AND Son</i>		ADDRESS <i>FEDERALSBURG, MD</i>		25a. REC'D BY REGISTRAR <i>NOV 15 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Trever</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be mailed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

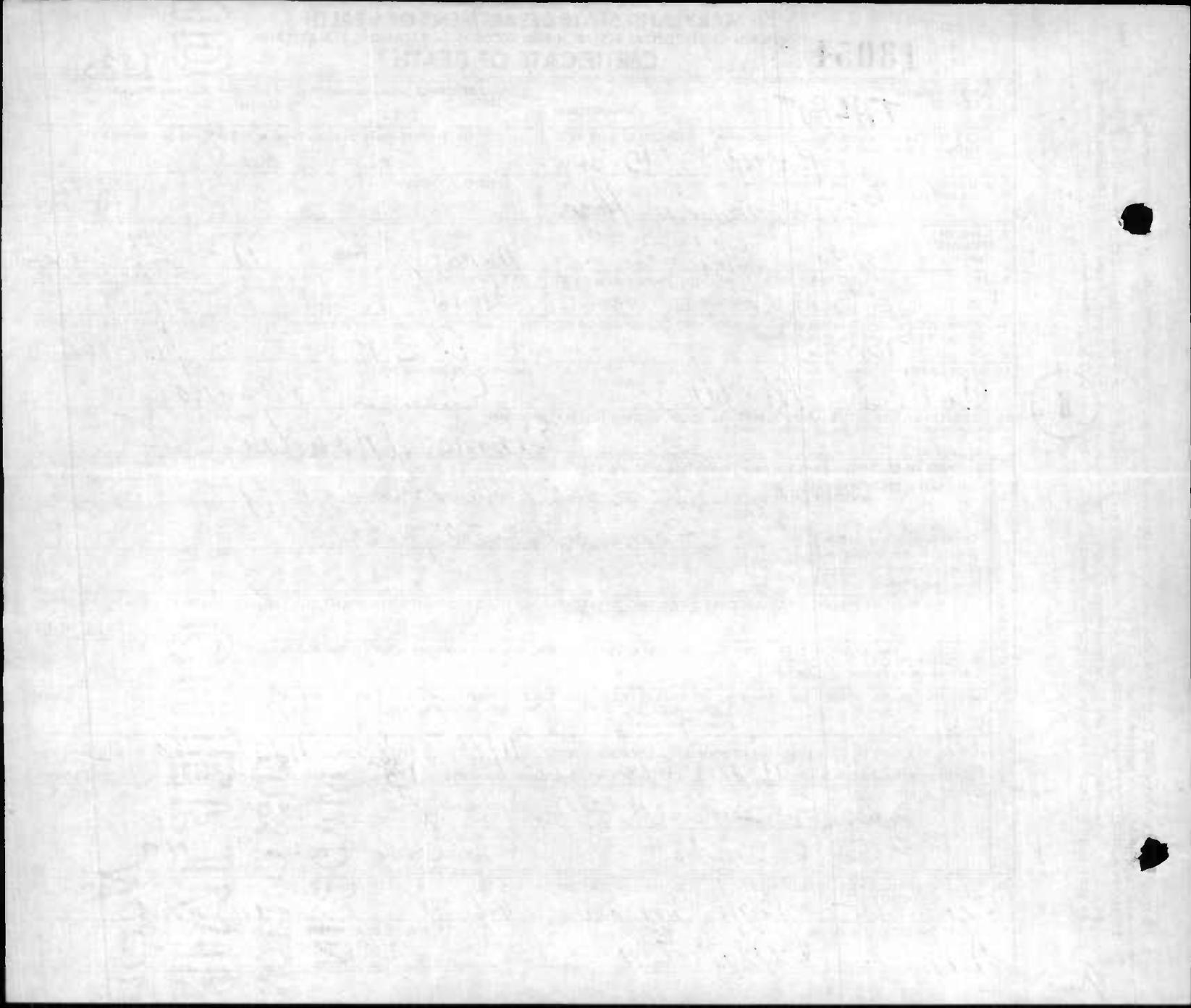
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13051

14389

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON.</b>		b. COUNTY <b>Talbot</b>			
c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cordova</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>		d. STREET ADDRESS <b>Box 169</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Baby</b>	First <b>M</b>	Middle <b>Eliz/</b>	Last <b>Pearl L.</b>		
4. DATE OF DEATH <b>Monday</b>	Month <b>11</b>	Day <b>26</b>	Year <b>1960</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>BLACK</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11/16/60</b>		
9. AGE (In years lost birthday) <b>1 yrs.</b>	10. IF UNDER 1 YEAR Months <b>10</b>	11. IF UNDER 24 HRS. Days <b>7</b>	12. Hours <b>10</b>		
13. FATHER'S NAME <b>Calvin Miller</b>	14. MOTHER'S MAIDEN NAME <b>Emma Monday</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Prematurity</b>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>11/16/60</b>	(County) <b>11/26/60</b>	(State) <b>1960</b>
21. I certify that (I) (this hospital) attended the deceased from <b>11/16/60</b> to <b>11/26/60</b> , that (I) (we) last saw the deceased alive on <b>11/26/60</b> and that death occurred at <b>1 PM</b> , from the causes and on the date stated above.				22b. DATE SIGNED	
22a. SIGNATURE <b>John E Bayburt MD</b>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John E. Bayburt</b>	ATTENDING M.D. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <b>205 Earle Ave EASTON MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Incineration</b>	23b. DATE THEREOF <b>12/2/60</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Memorial Hospital</b>	23d. LOCATION (City, town, or county) <b>EASTON MD</b> (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <b>None - Incinerated -</b>				25a. REC'D BY REGISTRAR <b>DEC 19 '60</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>
2080415 XVI					



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, during any event, within 72 hours after death.

VR A15 (4)  
 ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13052

13032

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Faxton</i>		c. LENGTH OF STAY IN 1b <i>6 days.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Preston</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>5X-1</i>	
3. NAME OF DECEASED (Type or print)	First <i>Gus</i>	Middle <i>Prager</i>	Last <i>Prager</i>
4. DATE OF DEATH	Month <i>November</i>	Day <i>19</i>	Year <i>1960</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>NOVEMBER 24, 1911</i>
9. AGE (In years lost birthday) <i>48 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>HARRISON AND JARBOE CO.</i>	11. BIRTHPLACE (State or foreign country) <i>NEW YORK STATE</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>GUSTAV ADOLPH PRAGER</i>		
14. MOTHER'S MAIDEN NAME <i>FANNY BARBOR</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.	17. INFORMANT <i>CARL E. PRAGER</i>	Address <i>ST MICHAELS MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>162-1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (1) (his hospital) attended the deceased from _____ to _____, that (1) (we) last saw the deceased alive on _____, and that death occurred at <i>Paxton</i> M.D. from the causes and on the date stated above.			
22a. SIGNATURE <i>Ellen Schmidt</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS <i>Paxton, Maryland</i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <i>20 Nov 1960</i>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>Nov 23, 1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>JUNIOR ORDER</i>	23d. LOCATION (City, town, or county) (State) <i>Preston</i> M.D.
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Frampton and Son</i>	ADDRESS <i>Federalburg, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 28 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be re-signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13033

13069

Item 1 Film 6278 13-61 et

1. PLACE OF DEATH

a. COUNTY

talbot

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Queen Anne

c. LENGTH OF STAY IN 1b

21 yr.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

Queen Anne

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Queen Anne

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES  NO

3. NAME OF DECEASED  
(Type or print)

Walter

First

Middle

Price

Last

4. DATE OF DEATH

11

13

1960

5. SEX

6. COLOR OR RACE

Male

Co

7. MARRIED  NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

DIVORCED

9. AGE (In years  
last birthday)

50 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Factory

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Doug Price

14. MOTHER'S MAIDEN NAME

MAUDESSIE Wilson

Address

Mrs. Helen Price Queen Anne's, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

023X

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

DUE TO

(b)

DUE TO

(c)

Myocardial failure

INTERVAL BETWEEN  
ONSET AND DEATH

2 weeks

Arteric valvular insufficiency

many years

Syphilitic aortitis

many years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?

YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. p. m.

20d. INJURY OCCURRED  
While at work  Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 8-21-1951 to 11-19-1960, that (I) (we) last saw the deceased alive on 11-19-1960, and that death occurred at 7 A.M. from the causes and on the date stated above.

22o. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town, or county)

22b. DATE SIGNED

11-19-60

M.D. ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

QUEEN ANNE, MARYLAND

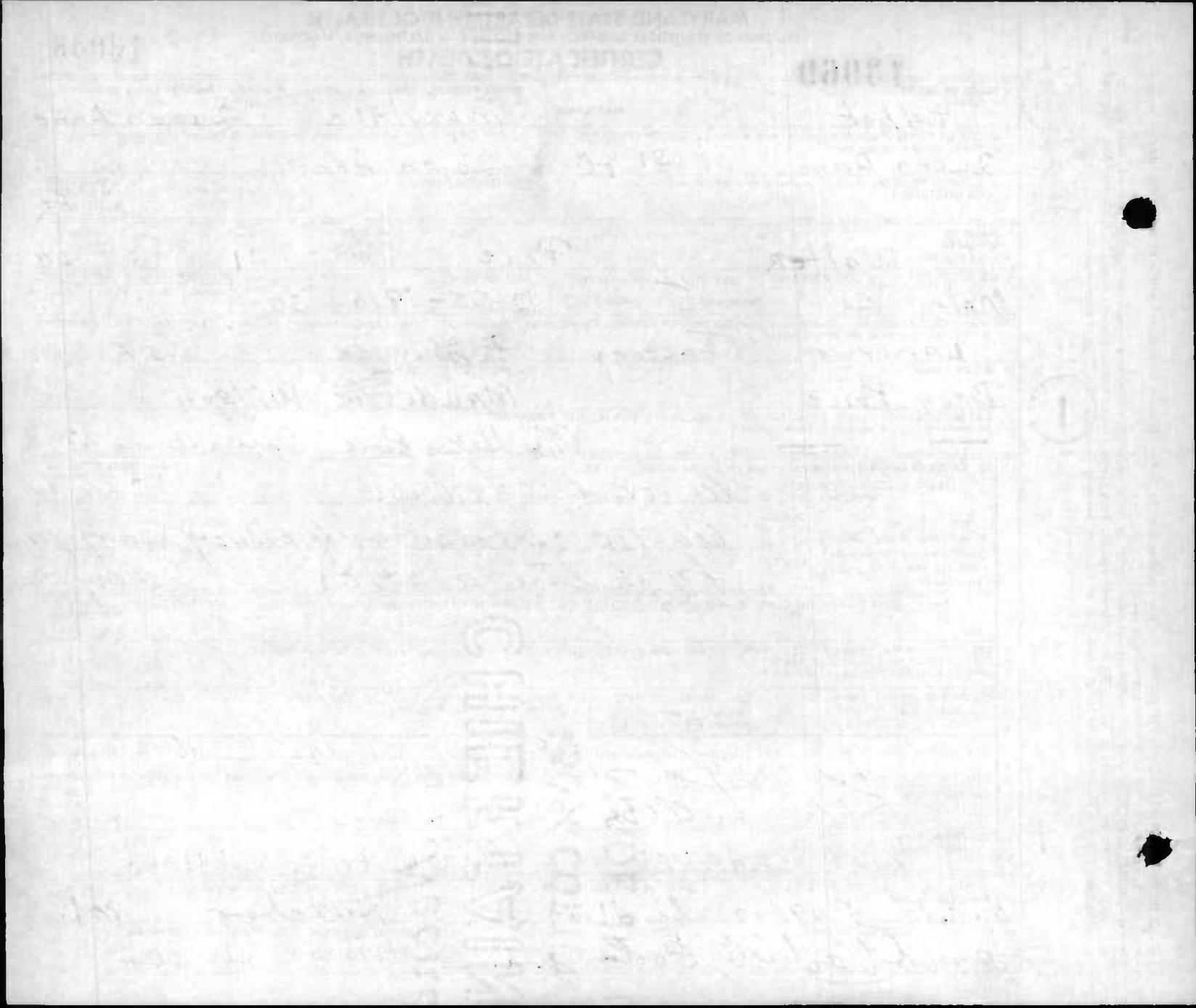
24. FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE NOV 22 '60

Arthur S. Thomas



1  
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 13053 CERTIFICATE OF DEATH

13034

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>18 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centreville</i>	
3. NAME OF DECEASED (Type or print) <i>Frederick</i>		First <i>Cornelius</i>	Middle <i>Conrad</i>
		Last <i>Quimby</i>	
4. DATE OF DEATH <i>November 30 1960</i>		Month <i>November</i>	Day <i>30</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>July 8-1889</i>		9. AGE (In years lost birthday) <i>71 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Small Farmer</i>	11. BIRTHPLACE (State or foreign country) <i>In Boston, Massachusetts</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph S. Quimby</i>	14. MOTHER'S MAIDEN NAME <i>Sophia Bayles</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-34-9248</i>	17. INFORMANT <i>Evelyn E. Quimby, PTA, Centreville, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>&lt;24 hrs.</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		Acute myocardial infarction	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		Arteriosclerotic heart disease	
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>11-29 1960</i> to <i>11-30 1960</i> , that (I) (we) last saw the deceased alive on <i>11-29 1960</i> , and that death occurred at <i>5:30 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Trever</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11-30-60</i>
22c. PHYSICIAN'S NAME (Type) <i>ROBERT W. TREYER</i>		22d. ADDRESS <i>Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec 2 - 1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Chestertown</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Bartolp, of Banton Bros. Centreville, Md.</i>		ADDRESS <i>100 Main Street, Centreville, Maryland</i>	25a. REC'D. BY REGISTRAR DATE <i>DEC 6 1960</i>
			25b. REGISTRAR'S SIGNATURE <i>Albert S. Graue</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

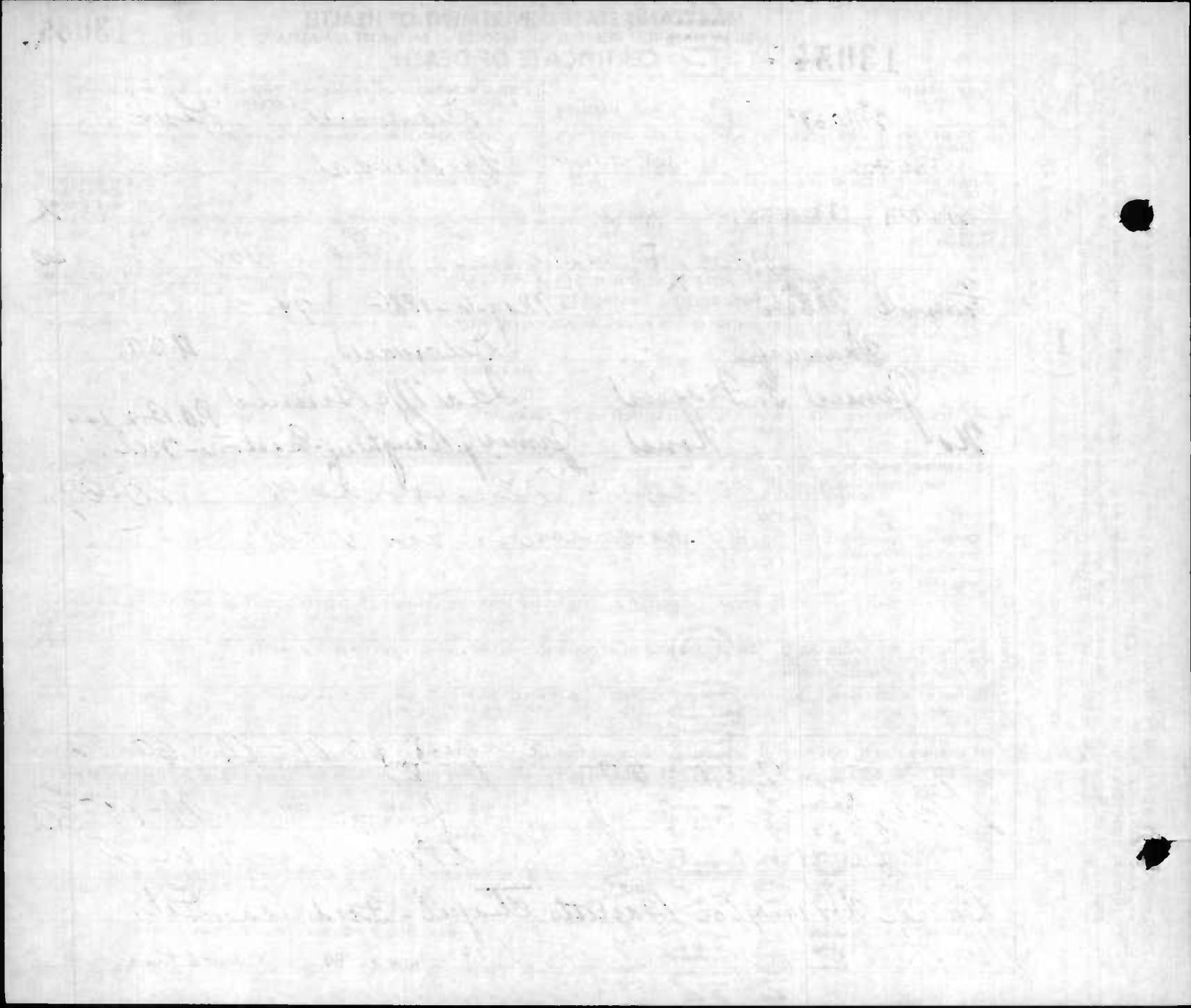
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13035

13054

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		
Talbot Co. MARYLAND		Delaware b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Easton	c. LENGTH OF STAY IN 1b 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederica		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		d. STREET ADDRESS 46 X-3		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		46 X-3		
3. NAME OF DECEASED (Type or print)	First Mabel F.	Middle Roughley	Last Nov 16 1960	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6 1886 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. Feier	14. MOTHER'S MAIDEN NAME Ida McGinnis	Address P.O. Box 149		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, Unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT James J. Roughley - Easton - Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO hypertension, etc vds (c)	INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 10-16, 1960</u> that (I) (we) last saw the deceased alive on <u>11-16-60</u> and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.	22. SIGNATURE Guy M. Preer	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11-17-60	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS Barrett's Chapel - Frederica, Del.	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov. 19, 1960		
23b. DATE THEREOF Nov. 19, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Barrett's Chapel - Frederica, Del.	23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE (Mrs.) R. H. Boyer, Harrington, Del.	ADDRESS	25a. REC'D BY REGISTRAR NOV 23 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13055

## CERTIFICATE OF DEATH

13036

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be required by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>9 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
d. STREET ADDRESS <u>OSX-2</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS Dykes Roe</u>		First <u>T</u>	Middle <u>H</u>
3. NAME OF DECEASED (Type or print) <u>THOMAS Dykes Roe</u>		Last <u>Roe</u>	4. DATE OF DEATH <u>November 17 1960</u>
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>JULY 8, 1892</u>		9. AGE (In years lost birthday) <u>68 yrs.</u>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Game Warden</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>THOS. F. Roe</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Dukes</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>	
16. SOCIAL SECURITY NO. <u>442-00-0000</u>		17. INFORMANT <u>Mrs. Martha Short</u>	Address <u>Denton, Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central embolism to left lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Subcardiac thrombosis</u>		( <u>?</u> )	
DUE TO (c) <u>Obit pectoralis, due to coronary atherosclerosis</u>		( <u>?</u> )	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8 AM</u> <u>1960</u> , to <u>17 hrs</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>16 hrs</u> <u>1960</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>17 hrs 60</u>	
22a. SIGNATURE <u>Thorston Harrison</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>17 hrs 60</u>
22c. PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>		22d. ADDRESS <u>Easton Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 20, 1960</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Denton</u>
23d. LOCATION (City, town, or county) <u>Denton, Md.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Moore &amp; Son</u>		ADDRESS <u>Denton, Md.</u>	25a. REC'D BY REGISTRAR <u>Cather S. Kinsella</u>
			DATE <u>NOV 22 '60</u>
			25b. REGISTRAR'S SIGNATURE <u>Cather S. Kinsella</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

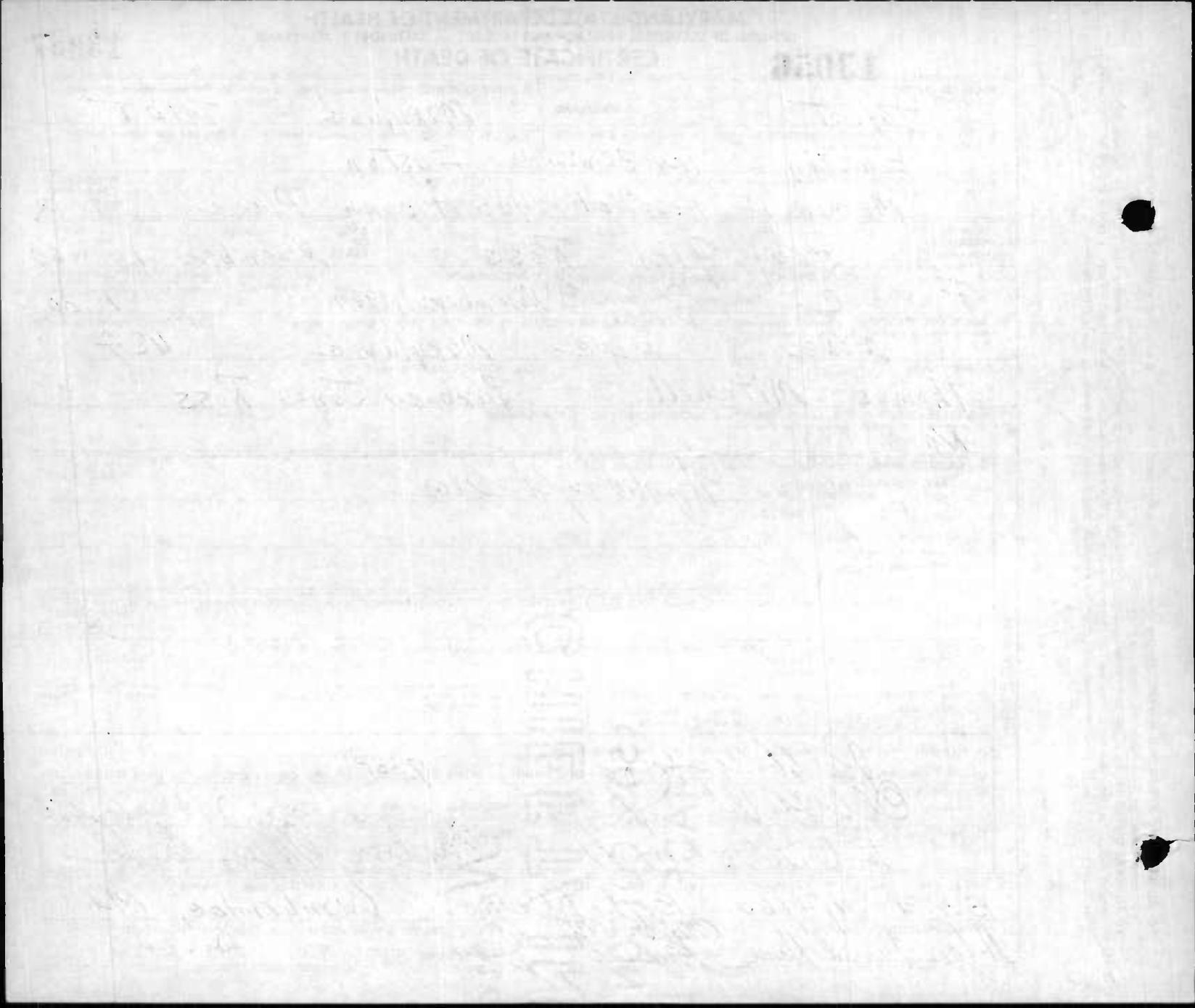
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13056 13057

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>1 hr. 30 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>		d. STREET ADDRESS <i>405 Abbury Place</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Baby Girl Ross</i>		First	Middle	Last	4. DATE OF DEATH <i>November 1 1960</i>	Month	Day	Year	
S. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>November 1, 1960</i>	9. AGE (In years lost birthday) yrs. <i>1</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Thomas Mitchell</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Jane Ross</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hydrocephalus</i>						INTERVAL BETWEEN ONSET AND DEATH			
344X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. <i>Pathologist</i>		19 to 19				22b. DATE SIGNED <i>2 November 1960</i>			
22a. SIGNATURE <i>Elle Schmidt</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		22d. ADDRESS <i>Easton, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/4/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Bethel Ceme.</i>		23d. LOCATION (City, town, or county) <i>Cambridge, Md</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Dr. Lee Funeral Home</i>		24b. ADDRESS <i>Cambridge, Md</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 9 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Dr. Lee</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13057

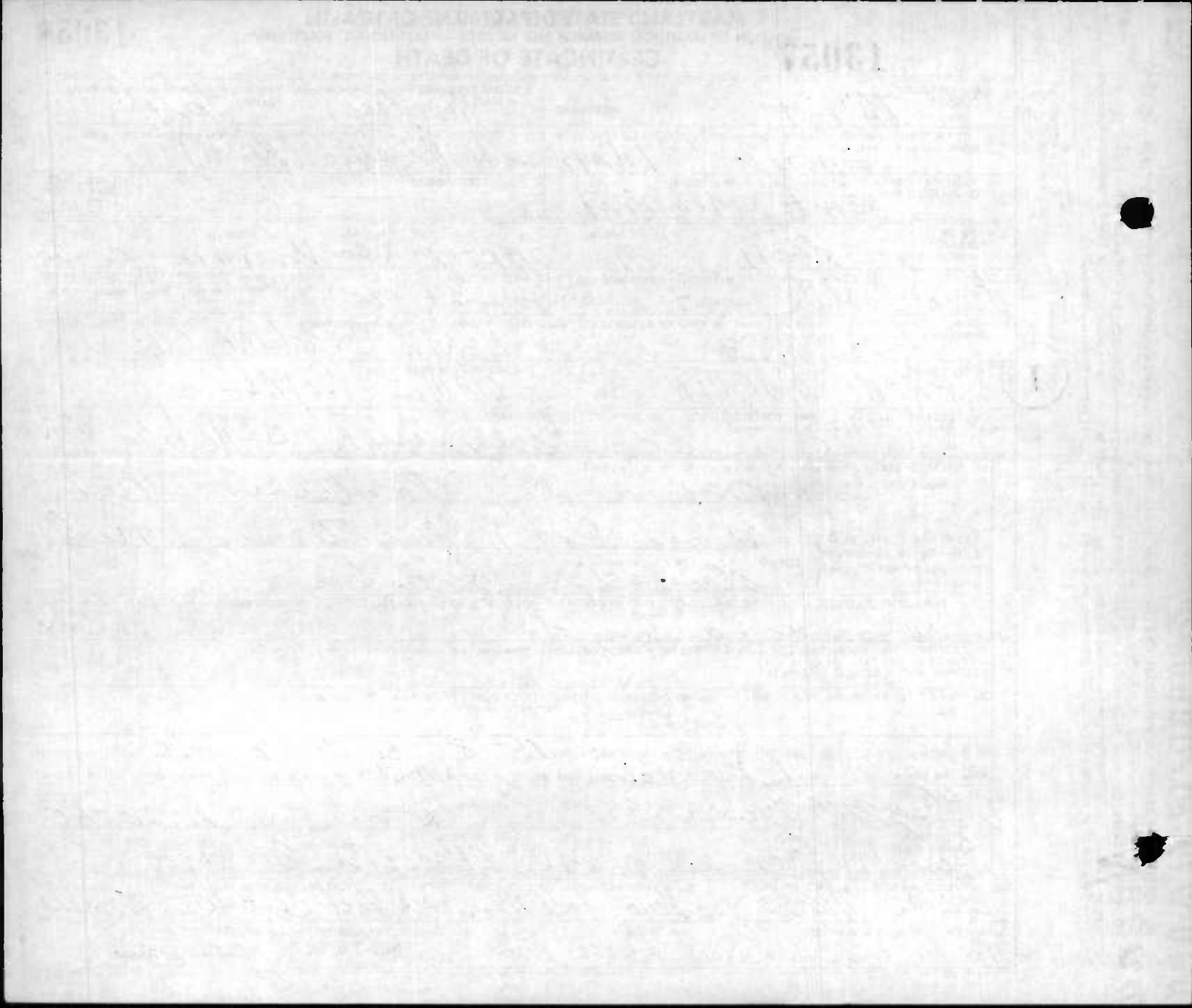
## CERTIFICATE OF DEATH

13058

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Talbot		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Talbot	
EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON MEMORIAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Neill	Middle M
4. DATE OF DEATH		Last SARTOR	Month November
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) 70 yrs.	
June 24, 1890		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME FRANK MARTIN		12. CITIZEN OF WHAT COUNTRY? U.S.	
14. MOTHER'S MAIDEN NAME MAMIE ROYALL		15. INFORMANT Ralph Sartor	
16. SOCIAL SECURITY NO.		Address 54 Michaels Rd	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>myocardial infarction</u> DUE TO (c) <u>atherosclerotic-obclusive</u> - coronary artery cl.	
20. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		21. I certify that (I) (this hospital) attended the deceased from <u>10-8-1960</u> to <u>11-26-1960</u> that (I) (we) last saw the deceased alive on <u>11-26-1960</u> and that death occurred at <u>9225R</u> from the causes and on the date stated above.	
22. PHYSICIAN'S NAME (Type) Fay M. Reeser, Jr. MD		22b. DATE SIGNED 11-26-60	
23a. BURIAL, CREMATION, REMOVAL SPECIES Burial		23b. DATE THEREOF Nov. 30, 1960	
23c. NAME OF CEMETERY OR CREMATORIUM Lauderdale Mem. Park		23d. LOCATION (City, town, or county) Fort Lauderdale Florida	
24. FUNERAL DIRECTOR'S SIGNATURE Marie E. Newmann, Son EASTON, Md.		25a. REC'D BY REGISTRAR DATE NOV 30 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13058 CERTIFICATE OF DEATH 13059

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>5 wks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tilghman</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>410 Winton Avenue</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Esta</b>	Middle <b>Viola</b>	Lost	4. DATE OF DEATH <b>November 30</b>	Month <b>1960</b>	Day Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 26, 1889</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hugh Haddaway</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca 1. Cummings</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>u kn.</b>		17. INFORMANT <b>Mrs. Ernest Harrison, Easton, Maryland</b>		Address <b>410 Winton Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
		DUE TO (c) <b>Arteriosclerosis</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Uremia and Carcinoma of Thyroid</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>1949</b> to <b>Nov. 30, 1960</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>Nov. 30, 1960</b> and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>M. Virginia Palmer</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>12/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. Virginia Palmer MD</b>		22d. ADDRESS <b>Easton, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/3/60</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Methodist Cemetery</b>		23d. LOCATION (City, town, or county) <b>Tilghman, Maryland</b> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Frampton Carroll</b>		ADDRESS <b>Easton, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 6 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

6161

PRINTED IN U.S.A. 1973

26081

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13070

## CERTIFICATE OF DEATH

Reg. Dist. No.

13040

1. PLACE OF DEATH o. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford		b. COUNTY Talbot				
c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxford				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) William Jennings Bryan		First	Middle			
4. DATE OF DEATH November		Month	Doy			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. B. DATE OF BIRTH Nov. 7, 1896		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self-employed		10b. KIND OF BUSINESS OR INDUSTRY waterman	11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William I. Smith				
14. MOTHER'S MAIDEN NAME Carrie Haddaway		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				
16. SOCIAL SECURITY NO. 220 12 0421		17. INFORMANT Mrs. Doyle Dawson Smith, Oxford, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) proven at surgery.		INTERVAL BETWEEN ONSET AND DEATH 3 months				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 10/14, 1957, to 11/14, 1960, that I last saw the deceased alive on 11/14, 1960, and that death occurred at 5 <sup>th</sup> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 11/15/60		
ACTUAL SIGNATURE T. J. Gladden M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/60		22c. NAME OF CEMETERY OR CREMATORIUM Oxford Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll		22d. LOCATION (City, town, or county) Oxford, Maryland		24a. REC'D BY REGISTRAR DATE NOV 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
		ADDRESS Easton, Md.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81. **БРОМІЛЯ-ІТЛАН** є ОДНОІЗВІСНОЮ АДДИЦІЯМ

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13059

13041

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

EASTON

c. LENGTH OF STAY IN 1b

13 1/2 hrs

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Memorial Hospital

## 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

MARYLAND

b. COUNTY

QUEEN ANNE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

GRASONVILLE

d. STREET ADDRESS

17x-2

e. IS RESIDENCE ON A FARM?

YES

NO

## 3. NAME OF DECEASED (Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

APRIL 12-1892

9. AGE (In years last birthday)

68 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

IF UNDER 1 YEAR IF UNDER 24 HRS.

HOUSEWIFE

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

JOSEPH BUCKLE

## 14. MOTHER'S MAIDEN NAME

UNKNOWN

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

B 218-03-3205

## 17. INFORMANT

MRS. HARVEY ROTH- GRASONVILLE

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4413X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Cerebral Vascular Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH 24 hrs.

Hyper tension Cardiovascular Dis.

4/5.

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

## 19. WAS AUTOPSY PERFORMED?

YES

NO

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m.20d. INJURY OCCURRED  
While at work  Not while at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ that (I) (we) last saw the deceased alive on \_\_\_\_\_ and that death occurred at \_\_\_\_\_ from the causes and on the date stated above.

1958 to 11/12 1960

## 22a. SIGNATURE

## 22c. PHYSICIAN'S NAME (Type)

S. KRECH SR.

ATTENDING MED. STAFF  
PHYS. DIRECTOR PHYS. SIGNED

## 22d. ADDRESS

EASTON, Md.

22b. DATE SIGNED

11/14/60

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

## 23b. DATE THEREOF

## 23c. NAME OF CEMETERY OR CREMATORIAL

## 23d. LOCATION (City, town, or county)

(State)

## 24. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

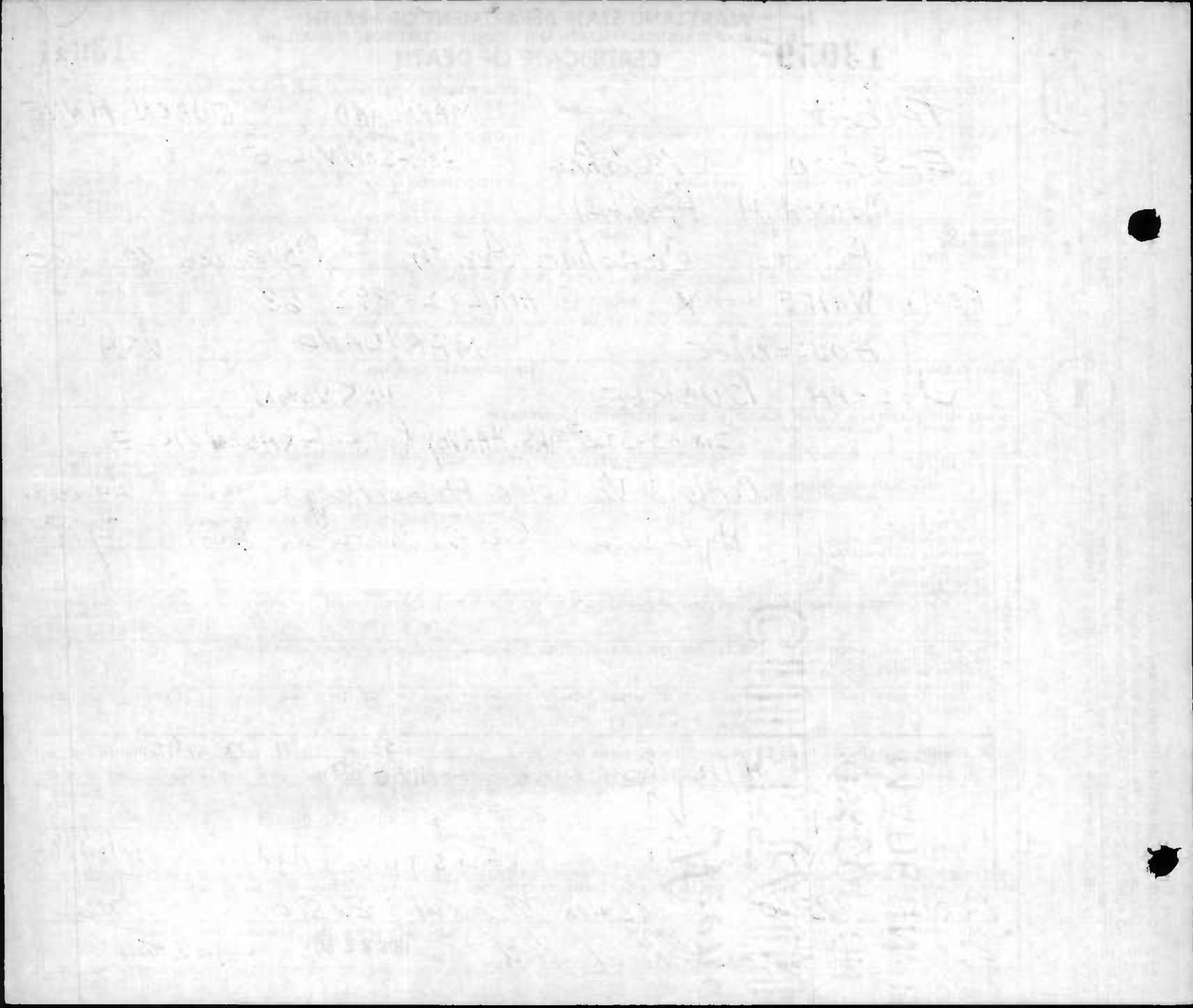
## 25a. REC'D BY REGISTRAR

DATE

NOV 28 '60

## 25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



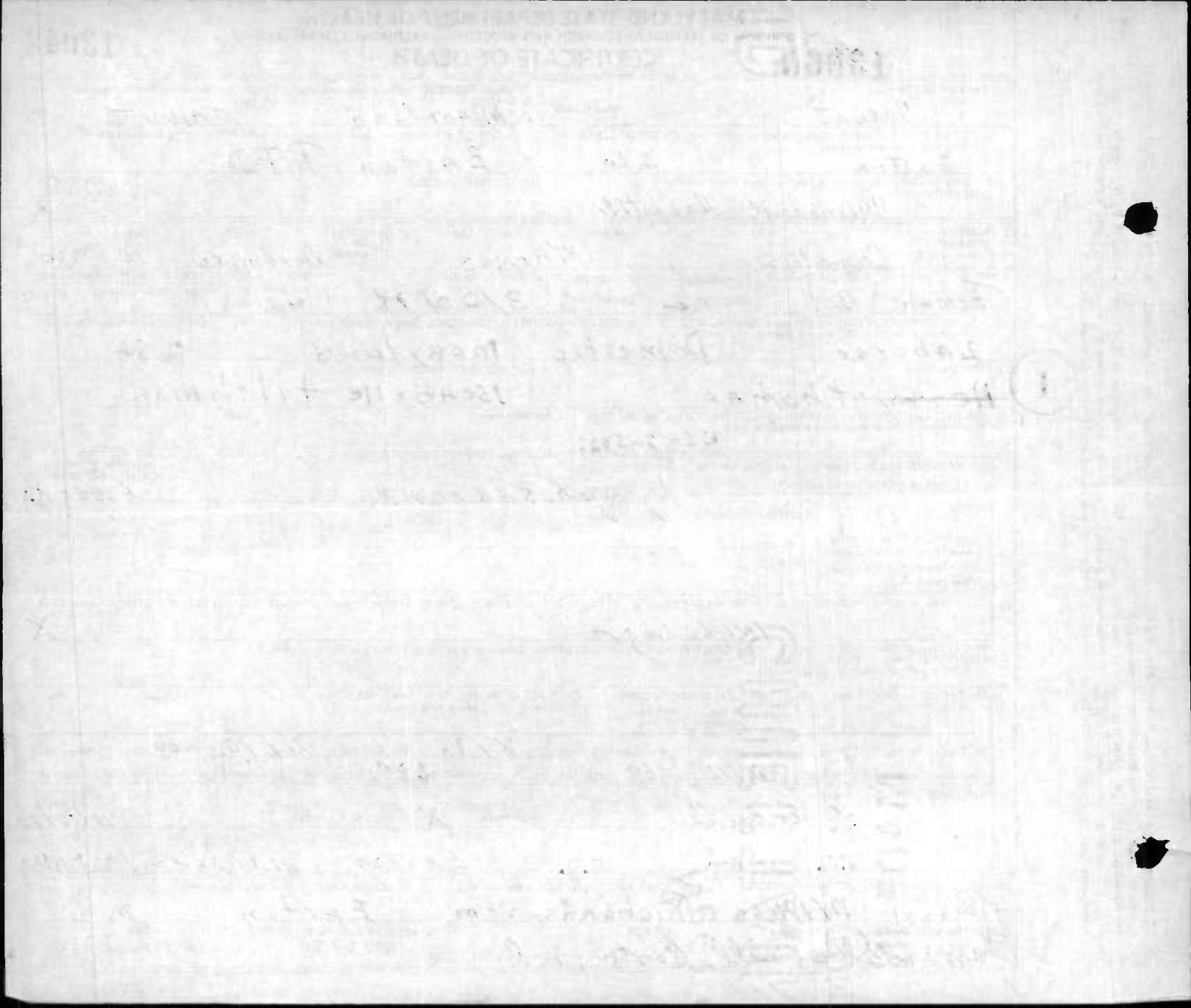
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13060

13042

1		13060		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <i>Talbot</i>		a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		b. COUNTY <i>Talbot</i>			
c. LENGTH OF STAY IN 1b <i>2da</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton RFD</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Carolyn</i>		First	Middle	Last	4. DATE OF DEATH <i>November 10 1960</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3/20/18</i>	9. AGE (In years last birthday) <i>42 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Henry Thomas</i>		14. MOTHER'S MARRIED NAME <i>Isabelle Tilghman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>15-18-5425</i>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks.</i>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>200-1</i>		DUE TO <i>Lymphosarcoma</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>INFLUENZA</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/13a</i> to <i>11/10</i> , 1960, that (I) (we) last saw the deceased alive on <i>11/10</i> 1960, and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>L.J. Eglader</i>		M.D. ATTENDING MED. STAFF PHYS. DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11/10/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>L.J. Eglader</i>		22d. ADDRESS <i>EASTON, MARYLAND 11/10/60</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/14/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Richards Cem</i>	
23d. LOCATION (City, town, or county) (State) <i>Easton Md.</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Marshall, Carter, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>NOV 17 '60</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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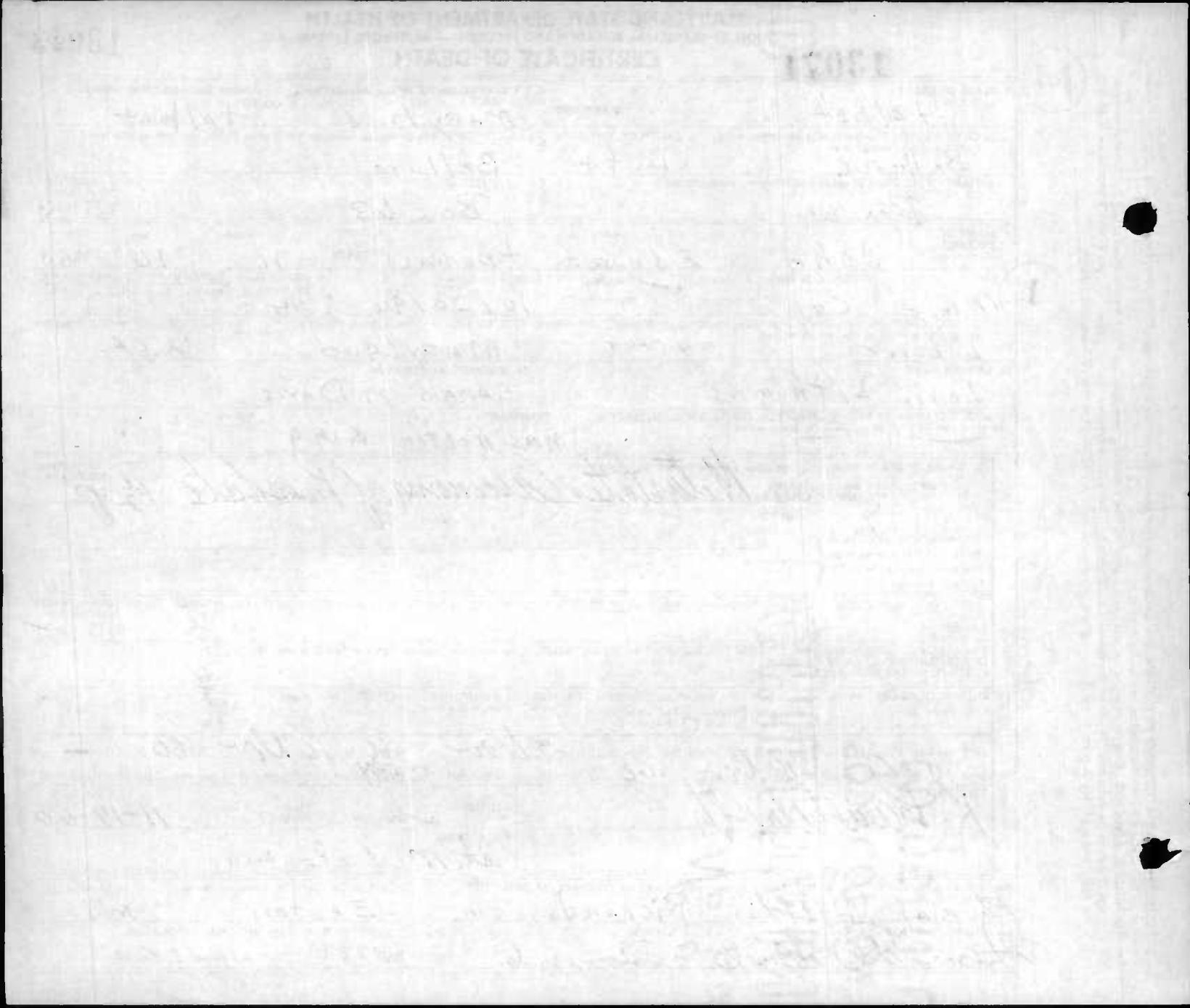
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13071

CERTIFICATE OF DEATH

13043

1. PLACE OF DEATH a. COUNTY <i>Calbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bellmore</i>		b. COUNTY <i>Calbot</i>	
c. LENGTH OF STAY IN 1b <i>21 to</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Bellmore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 63</i>		d. STREET ADDRESS <i>1 Box 63</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Edward</i>	Last <i>Thomas</i>
4. DATE OF DEATH	Month <i>11</i>	Month <i>16</i>	Year <i>1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/10/1906</i>
9. AGE (In years last birthday) <i>64 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Oyster</i>	12. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Louis J. Thomas</i>	14. MOTHER'S MAIDEN NAME <i>SARAH R. Davis</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	
16. SOCIAL SECURITY NO. <i>1777</i>	17. INFORMANT <i>Mrs Nettie King</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Prostate</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 yrs.</i>	
DUE TO <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>Nov</i>	Day <i>19</i>	Year <i>1960</i>
20d. INJURY OCCURRED While at work <input type="checkbox"/>	Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8 Nov 1960</i> to <i>16 Nov 1960</i> , that (I) <i>last</i> saw the deceased alive on <i>16 Nov 1960</i> and that death occurred on <i>12 Nov 1960</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>R. Paul Roth</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11-17-60</i>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>St. Michaels, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>11/17/60</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Richards, Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Easton</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>James D. O'Neil Easton, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>NOV 22 '60</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

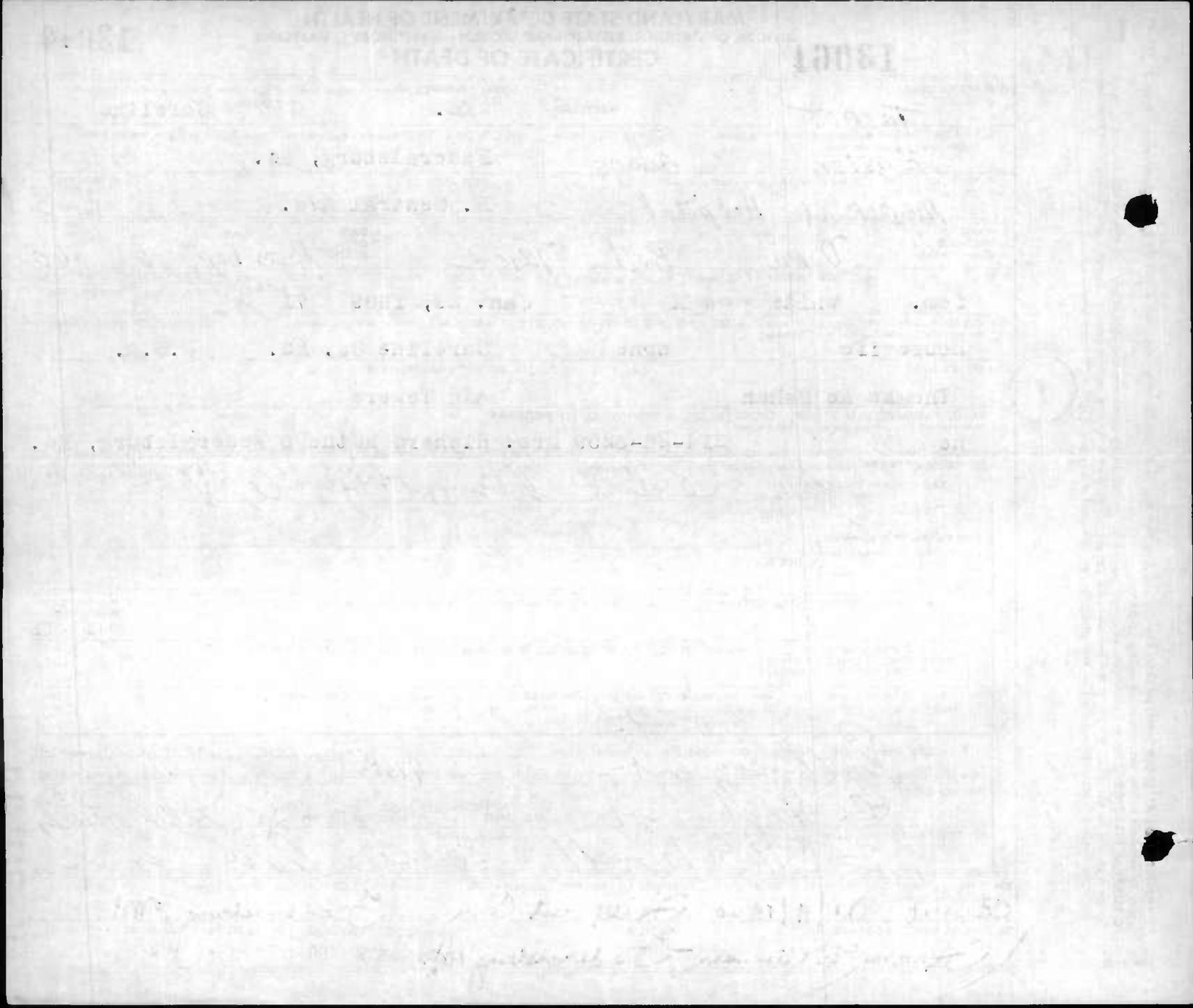
1  
M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13044

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg, Md.</i>	
e. STREET ADDRESS <i>E. Central Ave.</i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Dora</i>	First <i>Bell</i>	Middle <i>Trice</i>	Last <i>November 6 1960</i>
4. DATE OF DEATH <i>Nov. 29, 1889</i>	Month <i>71</i>	Day <i>1960</i>	Year
5. SEX <i>fem.</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 29, 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>Caroline Co. Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Thomas Mc Mahan</i>		14. MOTHER'S MAIDEN NAME <i>Ada Towers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-28-3259</i>	17. INFORMANT Address <i>Mrs. Richard Mathews Federalsburg, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33 IX</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral hemorrhage, left</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i></i>			
(c) DUE TO <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this Hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22o. SIGNATURE <i>E. C. H. Schmidt</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>7 Nov 1960</i>
22c. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>		22d. ADDRESS <i>Canton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/9/1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Hillcrest Cemetery</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey Williams - Federalsburg Md.</i>		ADDRESS <i></i>	25o. REC'D BY REGISTRAR DATE NOV 9 '60
			25b. REGISTRAR'S SIGNATURE <i>J. Kimes</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13045

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY

13066

TALBOT

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

ST. MICHAELS

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

RIO VISTA

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

QUEEN ANNE

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CHURCH HILL

d. STREET ADDRESS

1782

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)First  
THEODOREMiddle  
J.Last  
WALBERT4. DATE  
OF  
DEATHMonth  
NovDay  
24Year  
1960

## 5. SEX

Male

## 6. COLOR OR RACE

white

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

July 30, 1895

9. AGE (In years  
lost birthday)

65 yrs.

## 10. IF UNDER 1 YEAR

Months  
Days

## 11. IF UNDER 24 HRS.

Hours  
Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Theodore L. Walbert

## 14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

## INFORMANT

220-24-3431

MRS. ROBERT LOGAN SALISBURY MD

Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

190.9 Myocardial failure

INTERVAL BETWEEN  
ONSET AND DEATH

72h

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

DUE TO

(b) coagulopathy - severe

DUE TO

(c) Multiple Myeloma with

DUE TO

(d) generalized metastatic dissemination

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m.20d. INJURY OCCURRED  
While at work  Not white at work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 6-25, 1960, to 6-26-24, 1960, that I last saw the deceased alive on 11-24, 1960, and that death occurred at 11 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

11-27-60

## 22c. NAME OF CEMETERY OR CREMATORIUM

Sudlersville

## 22d. LOCATION (City, town, or county)

Sudlersville

(State)

Md.

## 23. FUNERAL DIRECTOR'S SIGNATURE

Sudlersville

## ADDRESS

Maryland

24a. REC'D BY REGISTRAR  
DATE

NOV 30 1960

## 24b. REGISTRAR'S SIGNATURE

Arthur S. Knott



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13062

CERTIFICATE OF DEATH

13046

PLACE OF DEATH  
o. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

MARYLAND

Falbot

c. LENGTH OF STAY IN 1b

Hours.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Caroline

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Federalsburg, Md.

d. STREET ADDRESS

Academy Ave.

e. IS RESIDENCE ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

male

white

7. MARRIED  NEVER MARRIED

WIDOWED

B. DATE OF BIRTH

DIVORCED

April 26, 1891

9. AGE (In years  
lost birthday)

69 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired food mfg. & broiler grower

10b. KIND OF BUSINESS OR INDUSTRY

Caroline Co. Md.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alonzo V. Wright

14. MOTHER'S MAIDEN NAME

Mary E. Windsor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

222-16-7843

17. INFORMANT

Mrs. Helen Wright Federalsburg, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

4  DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.

(b)

DUE TO

(c)

Myocardial Infarction

INTERVAL BETWEEN  
ONSET AND DEATH  
7 hrs.

Arteriosclerotic Heart Disease

?

Generalized Arteriosclerosis

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.

20d. INJURY OCCURRED  
While  Not while   
at work  at work

20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 11-19 1960 to 11-19 1960, that death occurred at 3:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE

11/19/60

M.D.

ATTENDING  
PHYS.

MED.  
DIRECTOR

STAFF  
PHYS.

22b. DATE  
SIGNED  
11-19-60

22c. PHYSICIAN'S  
NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

23b. DATE THEREOF  
11/19/60

23c. NAME OF CEMETERY OR CREMATORI

Hillcrest Cem.

23d. LOCATION (City, town, or county)

(State)

Federalsburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Sharon Bellamy - Federalsburg, Md.

25a. REC'D BY REGISTRAR

NOV 22 '60

DATE

25b. REGISTRAR'S SIGNATURE

Charles S. Trahan

